Cultural Models of Domestic Violence: Perspectives of Human Service Professionals

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Background and Statement of Research Question

Domestic violence is a pervasive social problem that demands attention from a variety of human service professionals who can link victims and their families to important services. A number of studies have found, however, that many human service professionals hold biases and stereotypes about domestic violence (Bograd, 1982; Ross & Glisson, 1991), and that some fail to provide victims with or refer them to necessary services (e.g., Eisikovits & Buchbinder, 1996; Kok, 2001). Research has also suggested that tackling these issues appropriately requires identifying professionals' ideas about the causes of and appropriate treatment for domestic violence (e.g., Davis & Carlson, 1981; Davis, 1984), and working to change ideas that impede appropriate service provision.

The question of professionals' beliefs about domestic violence has become more complex as domestic violence training programs have become more commonplace in many human service areas, especially in welfare offices and health care facilities, important potential referral sources. Despite implementing trainings and progressive referral programs, studies are still finding that domestic violence victims are not being informed of (through referral) and are not taking part in available services and programs in large numbers. There is some evidence that suggests that people have become increasingly sensitized to domestic violence issues, and are able to detect and therefore are unwilling to endorse common domestic violence stereotypes. This, of course, does not mean that professionals do not believe such stereotypes, but rather, that a different approach is needed to identify those beliefs. This study sought to examine those beliefs using a more refined method of collecting data that examines beliefs from the perspective of those who hold them, as opposed to traditional survey methods used in most research. Much previous research in this area has lacked a strong theoretical orientation, and has relied almost exclusively from results of survey research. While surveys are often useful, they have a number of drawbacks. Chief among these for the purposes of the research discussed here is the assumption that the researcher and participant share ideas about the domain of interest, in this case, domestic violence.

This study adopts an emic point of view, characteristic of cognitive anthropology, in which the participant's own perspective and language are used, rather than that of the researcher. The theoretical orientation is rooted in cultural consensus theory and therefore employs the concept of "cultural models," defined as socially distributed, shared schematic representations of reality that are used in thinking and behavior. The premise behind using such an orientation is that if we can better understand the distribution of cultural models and how they influence behavior, we can potentially change that behavior. The cultural consensus model, developed by Romney, Weller, and Batchelder (1986) was used to assess human service professionals' cultural models of domestic violence. The research asked the following questions: (1) What do human service professionals believe causes domestic violence, and how do they organize their thinking on the issue? (2) To what degree do human service professionals who serve similar client populations but work in different fields

share these beliefs? (3) How are beliefs about domestic violence distributed (i.e., what factors mitigate professionals' beliefs)? (4) How do professionals' beliefs about domestic violence develop, and how are these beliefs manifest in everyday practice?

General Methodology

A sample of 135 participants, made up of human service professionals and a general population comparison group, participated in the study. Domestic violence agency workers, welfare workers, and nurses made up the professional sample. A mixed qualitative and quantitative methodological approach was employed across the four phases of the study. Structured and unstructured interview techniques common to cognitive anthropology studies were used in the data collection. Each phase built on the one preceding it, often using some of the same participants and items, but ultimately each of the four phases constituted a separate study with unique approaches to data collection, and different analyses were performed to answer the research questions. The four phases of the study will therefore be discussed separately. Figure 1 provides a schematic of the steps of the research.

Phase I: Generating the Terms of the Domain

The first phase of the research focused on identifying human service professionals' beliefs about the causes of domestic violence. Twenty participants (five in each of the four groups) generated a list of factors that they believed cause domestic violence. A list of 32 different causes was compiled, and included a diverse array of terms, including weak social policy, stigma, having been abused, mental illness, and drug and alcohol abuse. Domestic violence workers tended to have lists that were shorter and focused more on societal issues (see Table 1), while other participants focused more on individual factors.

Phase II: Organizing the Domain

The second phase of the research examined how professionals organize their cultural model of domestic violence. A sample of 110 participants from the four groups was recruited to participate. A total of 22 domestic violence workers, 27 nurses, 57 welfare workers, and 29 members of the general population participated. Of the welfare workers, 33 were financial workers (7 child support, 21 food stamp, and 5 family assistance workers) and 24 child welfare workers (19 general child welfare and 5 educational leave workers).

Participants sorted the previously identified causes into piles based on their perceptions of the causes' similarity to one another, and described the categorizations they had made. Multi-dimensional scaling in ANTHROPAC provided a visual representation of participants' thinking about the causes' similarities to one another, and cluster analyses provided a guide for interpreting the boundaries of groups of terms (see Figure 2). These findings, along with participants' own descriptions of the piles they formed, resulted in the identification of four key themes participants appeared to use in organizing their

thinking about domestic violence. These themes tended to focus on victim issues or characteristics, perpetrator issues or characteristics, societal issues, and individual issues (see Figure 3). Domestic violence workers' and child welfare workers' multidimensional scaling analysis and clusters were quite similar to one another, although domestic violence workers tended to offer different explanations to why they placed items in the same piles. Specifically, where child welfare workers might label a pile that contained depression, low self-esteem, blaming oneself and the like "victim characteristics," domestic violence workers more often said that those terms described *outcomes* of domestic violence.

Overall, participants appeared to think about causes in terms of the extent to which they thought they were: (a) important, (b) controllable, (c) characteristic of victims or perpetrators, and (d) a cause or effect of domestic violence. These themes were carried over into the next phase of the study, as participants' sharing of domestic violence models was evaluated.

Phase III: Examining Sharing of the Domain

The third phase of the research focused on determining the extent to which professionals share ideas about domestic violence. A Likert-type survey was created based on findings from the previous phases of the research, and asked the 135 participants to evaluate each of the 32 causes generated in the first phase of the research with regard to the key themes identified in the second phase. Participants were asked to indicate the extent to which they believed that each factor was important and controllable, and were asked to indicate whether they thought each domestic violence factor was attributable to the (a) victim, (b) perpetrator, (c) both victim and perpetrator, or (d) neither victim nor perpetrator. Participants were also asked to indicate whether each domestic violence factor was a (a) cause of domestic violence, (b) effect of domestic violence, (c) both a cause and an effect of domestic violence, or (d) neither a cause nor an effect of domestic violence.

These data were submitted to cultural consensus analysis in ANTHROPAC to determine the extent to which participants shared a model of the causes of domestic violence (see Table 2). The findings revealed that all participants shared an understanding of the degree to which domestic violence factors are controllable and characteristic of victims and/or perpetrators, but did not share and understanding of whether the factors are causes and/or effects of domestic violence or the degree to which the factors were important. Child welfare workers, on the other hand, strongly shared ideas about the degree to which they believed the factors were important. Further analyses revealed that other service providers agreed with the child welfare workers' model, except for all but two domestic violence workers, indicating that domestic violence might be an example of a contested model of meaning. Investigation of the distribution of the models (via multiple regression in SPSS) revealed the importance of religion and race in predicting agreement with the child welfare workers' model. Being a domestic violence worker, however, was a strong negative predictor of agreement in that model.

Examination of responses to ratings of importance indicated that those that agreed with the child welfare worker model saw alcohol abuse, anger, power, control, drug use/abuse, and having witnessed abuse as all very important in contributing to domestic violence. They diverged, however, and did not agree on some items. Specifically, those that agreed with the child welfare model indicated that denial, financial dependence, jealousy, money problems, stress, and feeling isolated or alone were very important, but the domestic violence workers who did not agree that these were important. Instead, domestic violence workers continued to see societal issues as very important, while child welfare workers and those who agreed with them, did not.

Phase IV: Employing Cultural Models in Practice

The fourth phase of the research employed a purely qualitative framework in determining how professionals employ the cultural model(s) identified in previous phases of the research in their everyday practice. Eight participants (two child welfare workers, four domestic violence workers, a nurse, and a financial welfare worker), selected on the basis of their agreement with the child welfare model were interviewed about how they developed their model(s), the extent to which they employ those models in their work, and their views on collaboration and communication with other professionals on domestic violence issues. The interviews were tape recorded and transcribed, and analyzed for thematic content. Among other findings, the interviews revealed that child welfare workers see domestic violence in terms of family systems problems, while domestic violence workers, as women's advocates, approach the issue with regard to gender inequality and address society's role in partner violence. Nurses, recognizing their mandate for reporting child abuse, saw domestic violence as a matter for social workers, and financial welfare workers overall, were focused on paperwork and eligibility issues rather than on the well-being of their clients.

Utility for Social Work Practice

The victim of domestic violence has suffered a traumatic past and faces an uncertain future. The four phases of the research conducted here suggest that victims may face further obstacles as a result of the lack of a shared understanding of their dilemmas within the social service system. The fact that few domestic violence victims ever seek relief from their situation by obtaining the services of domestic violence workers (Brookoff et al., 1997) reinforces the importance of improving the skills of professionals who do encounter victims. Child welfare workers, most of whom are social workers in their educational training, focus rather squarely on children in their work. The sample was split between child protection workers and foster care workers, both of whom focus on providing services to children. Thus, their focus tends to be less on the adult partners and more on protecting children. The findings indicate that domestic violence workers employ a set of beliefs that is distinct from those of other

human service providers that are likely engaged when they encounter persons affected by domestic violence in practice. This research contributes to a growing body of work on the sharing and distribution of culture, and demonstrates a new way for social work researchers to analyze human behavior in the social environment. The findings also suggest directions domestic violence training programs might take with the ultimate goal of improving communication and collaboration among service professionals, thereby improving the quality of service delivery to domestic violence victims and linking them with crucial services.

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Tables and Figures

Figure 1. Sequence of Data Collection

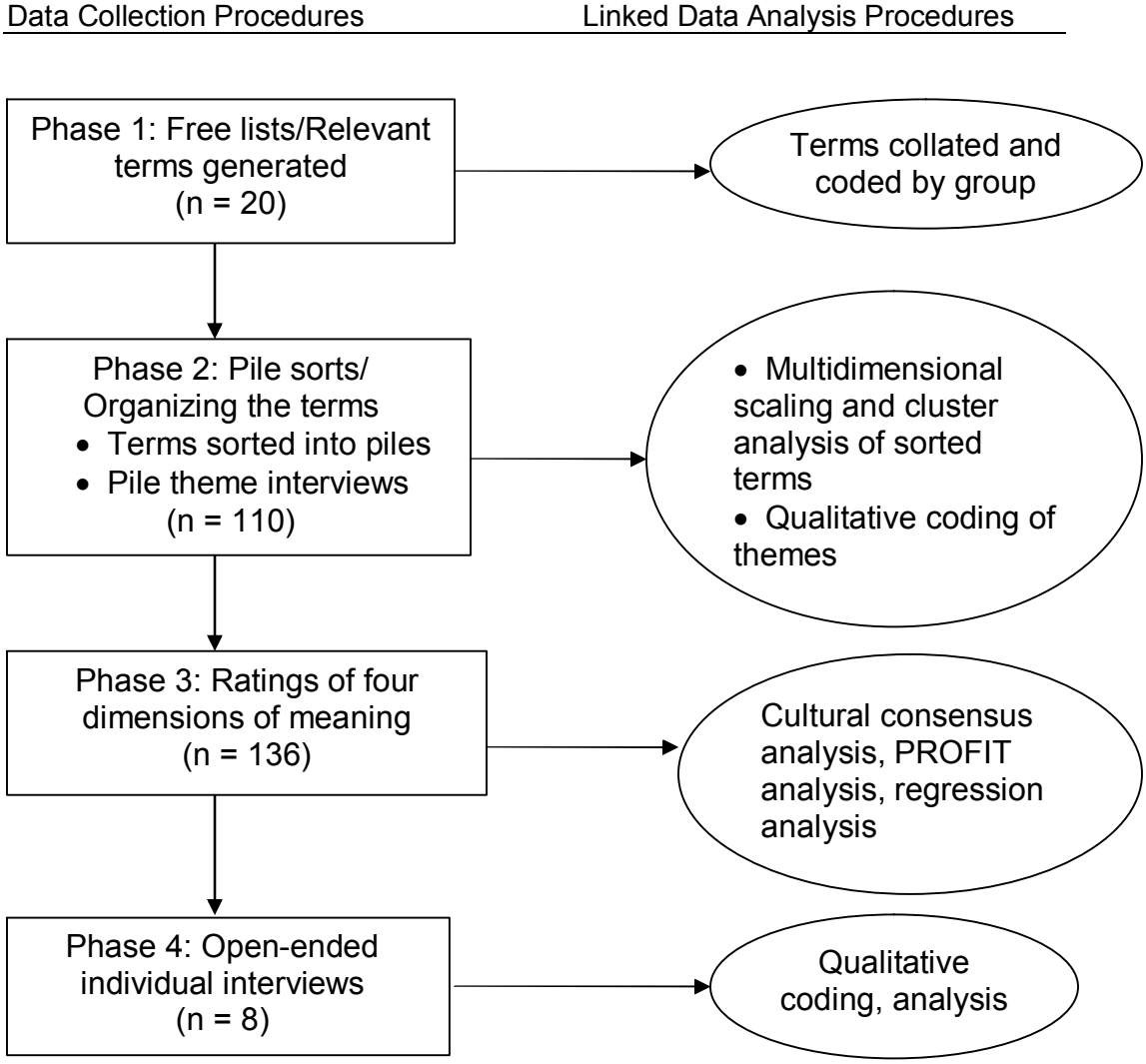
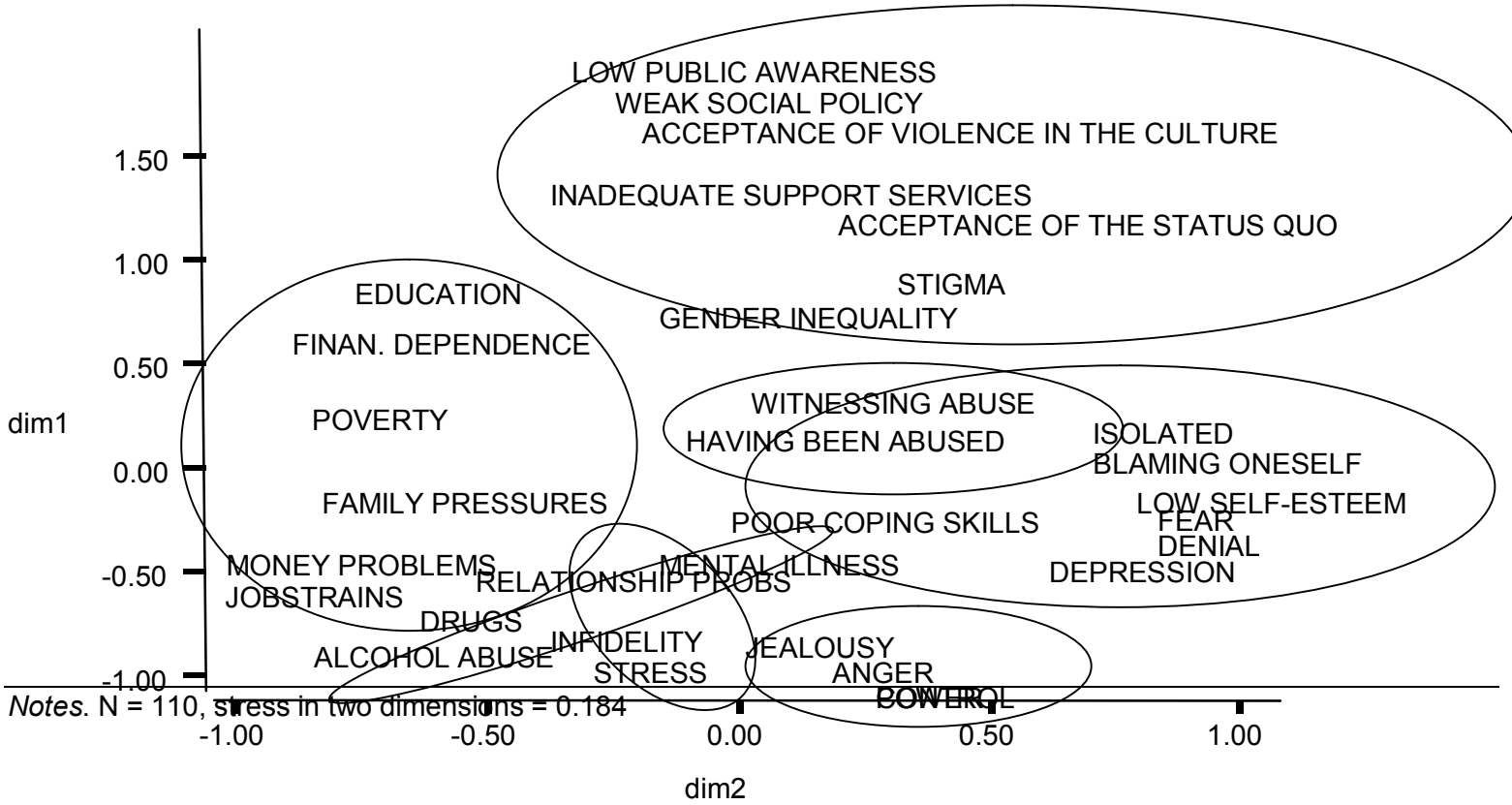


Figure 2. MDS and Cluster Analysis



Notes. N = 110, stress in two dimensions = 0.184

Figure 3. Linking MDS and Cluster Analysis with Qualitative Codes

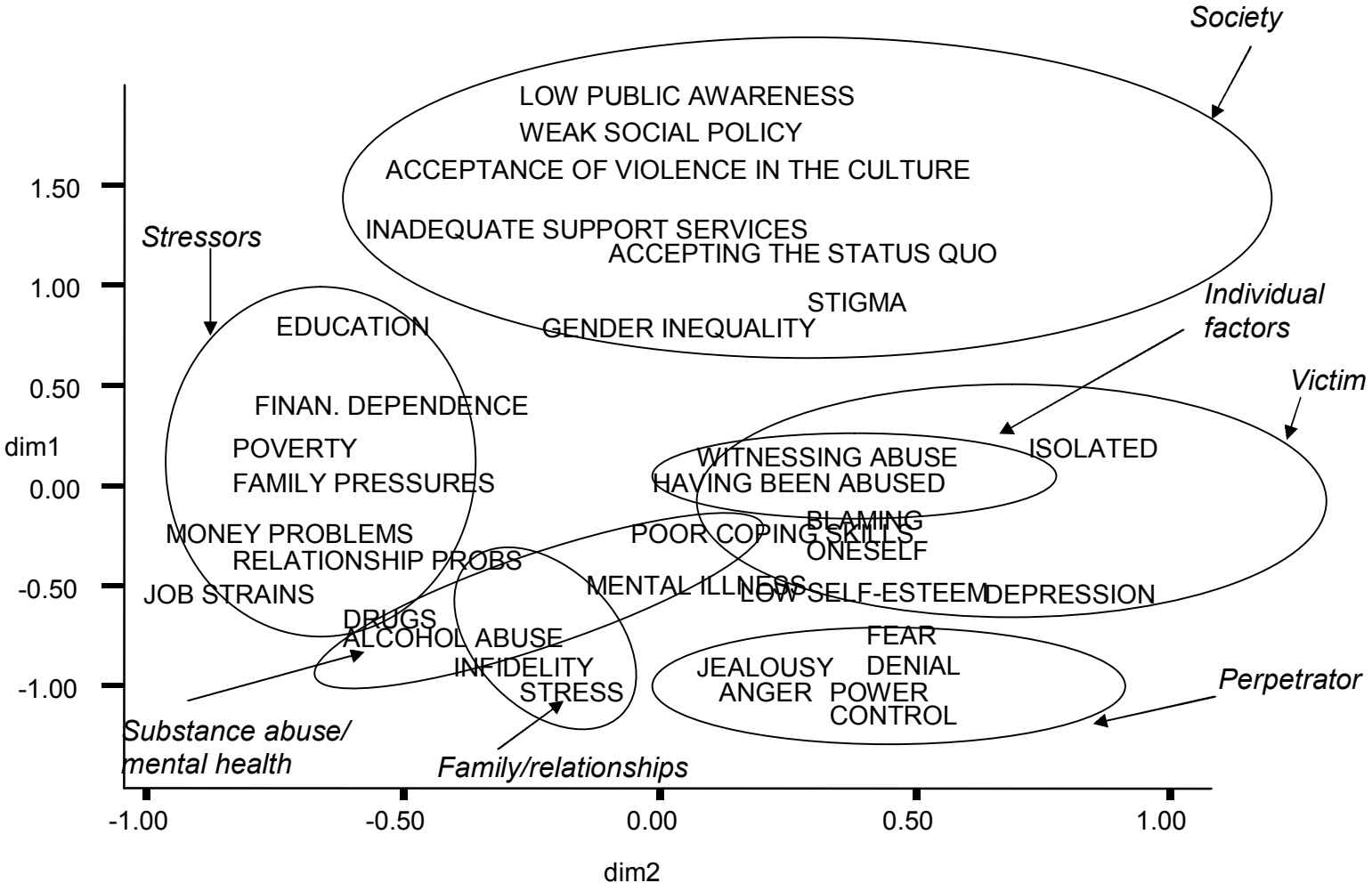


Table 1. Frequency of Listed Domestic Violence Causes by Group

Term	DV workers	Nurses	Welfare workers	Gen. pop.	Total
Drug use/abuse	0	4	5	1	10
Having witnessed abuse	1	2	4	3	10
Alcohol use/abuse	0	4	2	3	9
Feeling isolated or alone	1	2	4	1	8
Low self-esteem	0	3	2	3	8
Control	5	0	1	1	7
Power	5	1	0	1	7
Anger	0	2	4	1	6
Gender inequality/patriarchy	5	0	1	0	6
Poverty	0	2	2	2	6
Money problems	0	2	3	1	6
Job strains	0	2	1	2	5
Financial dependence	0	1	2	2	5
Mental Illness	0	1	1	3	5
Family pressures	0	3	1	1	5
Acceptance of violence in the culture	2	0	1	1	4
Denial	1	1	2	0	4
Having been abused	1	0	2	1	4
Stress	0	1	2	1	4
Poor coping skills	0	1	1	1	3
Problems in the relationship	0	1	1	1	3
Stigma	0	0	0	3	3
Depression	0	0	1	2	3
Low levels of public awareness	2	0	0	0	2
Lack of/low level of education	0	1	0	1	2
Accepting the status quo	0	1	0	1	2
Blaming oneself	0	1	0	1	2
Fear	0	2	0	0	2
Inadequate support services	2	0	0	0	2
Weak social policy	2	0	0	0	2
Infidelity	0	0	1	0	1
Jealousy	0	1	0	0	1

Table 2. Importance Answer Key and Consensus Analysis Results

	DV workers (n = 22)	Nurses (n=27)	Child welfare (n = 24)	Finan. assist. (n = 33)	Gen. pop. (n =30)	Total (N = 136)
Accep viol cult	6.25	4.90	5.38	5.09	4.57	4.92
Accep stat quo	4.93	4.11	3.80	4.02	4.04	3.93
Alcohol abuse	3.66	6.75	6.10	6.72	6.52	6.59
Anger	2.92	6.05	6.29	6.11	6.23	6.35
Blaming self	5.64	4.56	5.43	4.22	4.79	4.55
Control	7.04	5.95	6.36	5.92	6.03	6.11
Denial	5.31	4.84	5.45	4.90	4.90	4.98
Depression	2.75	5.39	4.50	4.86	4.89	5.05
Drug use/abuse	3.84	6.62	6.36	6.44	6.32	6.51
Education	4.42	4.88	3.40	4.64	3.52	3.97
Fam. pressures	4.31	5.49	5.37	4.90	4.98	5.20
Fear	4.99	5.13	5.21	4.76	5.04	5.01
Feeling isolated	5.90	4.98	5.79	4.30	4.79	4.88
Finan. depend.	6.06	4.88	5.94	5.06	5.06	5.10
Gender inequ.	6.79	4.67	4.87	3.96	4.43	4.34
Been abused	4.97	6.38	5.82	5.92	6.35	6.12
Witness abuse	5.37	5.09	5.18	4.89	5.59	5.21
Inad. suppt. sys	6.07	5.77	5.35	4.59	4.38	4.95
Infidelity	1.93	5.25	4.49	4.85	4.37	4.91
Jealousy	2.90	5.47	5.45	5.48	5.03	5.51
Job strains	3.46	5.16	4.81	5.16	5.13	4.99
Low pub. aware	6.35	3.98	3.85	3.64	3.99	3.77
Mental illness	2.97	5.58	4.85	5.68	5.22	5.45
Money probs	2.78	5.89	5.40	6.12	5.31	5.77
Poor coping	3.30	5.93	5.89	5.56	4.95	5.67
Poverty	3.84	5.60	4.19	5.00	4.51	4.76
Power	7.18	6.02	6.30	5.35	5.81	5.89
Relat. problems	2.26	5.46	5.56	5.18	4.81	5.36
Low self-est.	3.24	5.60	5.70	5.19	5.12	5.57
Stigma	4.86	4.46	3.55	3.88	3.68	3.80
Stress	3.21	5.93	5.68	5.33	5.24	5.60
Weak policy	6.45	4.11	3.72	3.65	4.03	3.71
Cultural Consensus Analysis						
Eigenval. ratio	1.674	2.724	3.093*	2.797	2.257	1.959
Mean compet-ence (SD)	.31 (.37)	.475 (.17)	.533 (.16)	.454 (.22)	.430 (.25)	.389 (.27)

Note. * indicates levels of sharing to conclude cultural consensus.